

Connecticut Society for Cardiac Rehabilitation (CSCR) 2017 Membership Application

Directions: Please complete the entire form and print clearly. All of the information below is for the sole use of the CSCR and will not be given to other organizations. **Note that the majority of correspondence is conducted via email.**

Last Name: _____ First Name: _____

Professional Suffix(es) (include those you prefer to be listed next to your name for mailings, for example: BS, MS, RN, APRN, RCEP, PhD, PA-C, etc.): _____

Mailing Address: _____

City: _____

State: _____ Zip Code: _____

E-mail Address: _____

Phone (include area code): Home: _____ Work: _____

Name of Affiliation/Employer: _____

Cardiac rehabilitation program director/manager/coordinator? : Yes No

Currently serve on the CSCR Executive Committee? : Yes No

Member of American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)? : Yes No

Member of the American College of Sports Medicine (ACSM)? : Yes No

Highest Academic Degree (check one): MD PhD MS or MA BS or BA
 Other (explain) _____

Field of Expertise (check all that apply): Nursing Exercise Physiology Physical Therapy
 Social Work Dietary Other (explain): _____

Annual professional membership fee is \$60. Student fee is \$30 (copy of student ID required).

Please make checks payable to CSCR.

Mail to: Dale Baker, R.N., B.S.N.
W. W. Backus Hospital
Cardiac & Pulmonary Rehabilitation
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Norwich, CT 06360

Questions: Dale Baker
dale.baker@hhchealth.org
860-823-6336

For Office Use Only:

Date payment received: _____ Amount: \$ _____ Check number: _____